

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN5202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED 06/30/2021
NAME OF PROVIDER OR SUPPLIER DONALSON CARE CENTER		STREET ADDRESS, CITY, STATE ZIP CODE 1681 WINCHESTER HIGHWAY FAYETTEVILLE, TN 37334		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments A licensure survey was conducted from 6/28/2021 to 6/30/2021 at Donalson Care Center. No deficiencies were cited related to the licensure survey under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

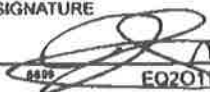
Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

 Administrator

7/16/21

EQ2011

If continuation sheet 1 of 1